		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020131

Facility Name: JACKSONVILLE CONVALESCENT CENTER

Address: 1517 W. WALNUT (Number) JACKSONVILLE (City) 62650 (Zip Code)

County: MORGAN

Telephone Number: 217-243-6451 **Fax #** 217-243-8295

IDPA ID Number: 370983545001

Date of Initial License for Current Owners: AUGUST 1974

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT		[X] PROPRIETARY		[ ] GOVERNMENTAL	
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** 217-787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/03 to 06/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) JERRY W. JENNINGS
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	61	Skilled (SNF)	61	22,326	1
2		Skilled Pediatric (SNF/PED)			2
3	27	Intermediate (ICF)	27	9,882	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	88	32,208	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,617	4,617	8
9	SNF/PED					9
10	ICF	16,846	8,427		25,273	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,846	8,427	4,617	29,890	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.80%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/74

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 61 and days of care provided 4,617

Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 6/30/04 Fiscal Year: 6/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CEN # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	100,555	12,876	8,814	122,245		122,245		122,245			1
2	Food Purchase		130,587		130,587		130,587	(4,077)	126,510			2
3	Housekeeping	35,537	13,255		48,792		48,792		48,792			3
4	Laundry	20,872	12,945		33,817		33,817		33,817			4
5	Heat and Other Utilities			62,415	62,415		62,415		62,415			5
6	Maintenance	36,154	18,956	33,227	88,337		88,337	1,000	89,337			6
7	Other (specify):* **Utility Workers**	30,406			30,406		30,406		30,406			7
8	**TOTAL General Services**	223,524	188,619	104,456	516,599		516,599	(3,077)	513,522			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,160,849	221,173	65,238	1,447,260	(145,765)	1,301,495	6,309	1,307,804			10
10a	Therapy	77,896	1,726	260,447	340,069	(260,447)	79,622		79,622			10a
11	Activities	48,617	2,327		50,944		50,944		50,944			11
12	Social Services	18,138		5,117	23,255		23,255		23,255			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,305,500	225,226	342,802	1,873,528	(406,212)	1,467,316	6,309	1,473,625			16
	C. General Administration											
17	Administrative	78,061		10,792	88,853	2,276	91,129	46,684	137,813			17
18	Directors Fees											18
19	Professional Services			268,054	268,054		268,054	(258,285)	9,769			19
20	Dues, Fees, Subscriptions & Promotions			10,412	10,412		10,412	(4,465)	5,947			20
21	Clerical & General Office Expenses	34,362	12,785	5,663	52,810		52,810	32,552	85,362			21
22	Employee Benefits & Payroll Taxes			263,742	263,742		263,742	18,340	282,082			22
23	Inservice Training & Education			1,228	1,228		1,228	1,394	2,622			23
24	Travel and Seminar			6,017	6,017	(5,738)	279	651	930			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			78,488	78,488		78,488	448	78,936			26
27	Other (specify):*			39,585	39,585		39,585	(39,585)				27
28	**TOTAL General Administration**	112,423	12,785	683,981	809,189	(3,462)	805,727	(202,266)	603,461			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,641,447	426,630	1,131,239	3,199,316	(409,674)	2,789,642	(199,034)	2,590,608			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER #0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			23,129	23,129		23,129	5,520	28,649			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,700	6,700		6,700	(6,700)				32
33	Real Estate Taxes			24,116	24,116		24,116		24,116			33
34	Rent-Facility & Grounds			132,000	132,000		132,000	(126,236)	5,764			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			185,945	185,945		185,945	(127,416)	58,529			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					409,674	409,674		409,674			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,312	48,312		48,312		48,312			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			48,312	48,312	409,674	457,986		457,986			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,641,447	426,630	1,365,496	3,433,573		3,433,573	(326,450)	3,107,123			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,337)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,415)	30		9
10	Interest and Other Investment Income	145	32		10
11	Discounts, Allowances, Rebates & Refunds	(517)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,631)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(470)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(941)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(33,954)	27		24
25	Fund Raising, Advertising and Promotional	(3,674)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(540)	20		28
29	Other-Attach Schedule VENDING	(1,740)	2		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (54,074)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(272,376)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (272,376)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (326,450)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	THERAPY	X		260,447	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		12,095	10	42
43	Prescription Drugs	X		106,000	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule O2,Ambul	X		26,515	10	45
46	Other-Attach Schedule PartA Anc	X		4,617	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 409,674		47

STATE OF ILLINOIS
JACKSONVILLE CONVALESCENT CENTER
ID# 0020131
Report Period Beginning: 07/01/03
Ending: 06/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,337)	0	0	0	0	0	0	0	0	0	0	(2,337)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,337)	0	0	0	0	0	0	0	0	0	0	(2,337)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	293	0	0	0	0	0	0	0	0	0	293	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(941)	(257,450)	0	0	0	0	0	0	0	0	0	(258,391)	19
20	Fees, Subscriptions & Promotions	(4,684)	175	0	0	0	0	0	0	0	0	0	(4,509)	20
21	Clerical & General Office Expenses	(517)	0	0	0	0	0	0	0	0	0	0	(517)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(293)	0	0	0	0	0	0	0	0	0	(293)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(39,585)	0	0	0	0	0	0	0	0	0	0	(39,585)	27
28	**TOTAL General Administration**	(45,727)	(257,275)	0	0	0	0	0	0	0	0	0	(303,002)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(48,064)	(257,275)	0	0	0	0	0	0	0	0	0	(305,339)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER **#** 0020131 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(4,415)	7,669	0	0	0	0	0	0	0	0	0	3,254	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	145	(6,845)	0	0	0	0	0	0	0	0	0	(6,700)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(132,000)	0	0	0	0	0	0	0	0	0	(132,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,270)	(131,176)	0	0	0	0	0	0	0	0	0	(135,446)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(52,334)	(388,451)	0	0	0	0	0	0	0	0	0	(440,785)	45

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
H. RAYMOND KLEIN	25%	HILLTOP NURSING HOME	CHARLESTON	Nursing Home Mngrs	SPRINGFIELD	MANAGEMENT
SAM KLEIN	25%	MEADOW MANOR	TAYLORVILLE	J'ville Land Trust	SPRINGFIELD	LAND TRUST
DORYS BERG, TRUSTEE	50%	MENARD CONVALESCENT CENTER	PETERSBURG			
		SUNRISE MANOR OF VIRDEN	VIRDEN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 132,000	JACKSONVILLE CONVALESCENT CENTER LAND TRUST	100.00%	$	$ (132,000)	1
2	V	30	DEPRECIATION		JACKSONVILLE CONVALESCENT CENTER LAND TRUST	100.00%	7,669	7,669	2
3	V	20	TRUST FEES		JACKSONVILLE CONVALESCENT CENTER LAND TRUST	100.00%	175	175	3
4	V	32	INTEREST		JACKSONVILLE CONVALESCENT CENTER LAND TRUST	100.00%	(145)	(145)	4
5	V	32	INTEREST		JACKSONVILLE CONVALESCENT CENTER LAND TRUST	100.00%	(6,700)	(6,700)	5
6	V								6
7	V	19	MANAGEMENT FEES	266,815	NURSING HOME MANAGERS, INC.	50.00%		(266,815)	7
8	V	VAR	SEE ATTACHED SCHEDULES		NURSING HOME MANAGERS, INC.	50.00%	116,075	116,075	8
9	V	19	ACCOUNTING		NURSING HOME MANAGERS, INC.-DIRECT ALLOCATION	50.00%	9,365	9,365	9
10	V	24	TRAVEL	293	TO TRANSFER 31% OF HOME OFFICE TRAVEL	50.00%		(293)	10
11	V	17	ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE - PER DESK REVIEW	50.00%	293	293	11
12	V								12
13	V								13
14	Total			$ 399,108			$ 126,732	$ * (272,376)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CEN' # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	H. RAYMOND KLEIN	OWNER	MANAGEMENT	25.00					$ 2,603	17 - 7	1
2											2
3											3
4											4
5		H. RAYMOND KLEIN WAS PAID BY NURSING HOME MANAGERS, INC., A RELATED									5
6		ORGANIZATION. TOTAL COMPENSATION OF $10,010 WAS ALLOCATED AMONG									6
7		THE FIVE RELATED NURSING HOMES BASED UPON 10 HOURS PER WEEK FOR									7
8		H. RAYMOND KLEIN.									8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,603		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NURSING HOME MANAGERS, INC.
Street Address: 2653 WEST LAWRENCE - SUITE B
City / State / Zip Code: SPRINGFIELD, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE ATTACHED SCHEDULES				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENT # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	J'VILLE LAND TRUST	X		WORKING CAPITAL		12/6/02	74,000			5.0000	6,700	6
7												7
8												8
9	TOTAL Facility Related						$ 74,000	$			$ 6,700	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 74,000	$			$ 6,700	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 39,129	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 26,086	2
3. Under or (over) accrual (line 2 minus line 1).		$ (13,043)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 37,159	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 24,116	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	25,115	8
	2000	25,319	9
	2001	26,027	10
	2002	26,086	11
	2003	24,773	12

LINE 4: 2003 TAX BILL $24,773
6/12 OF $24,773 $12,386
TOTAL ACCRUAL $37,159

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME JACKSONVILLE CONVALESCENT CENTER COUNTY MORGAN

FACILITY IDPH LICENSE NUMBER 0020131

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE (217) 787-8530 FAX #: (217) 787-9840

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200:

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-18-301-002	JACKSONVILLE CONV. CTR.	$ 24,772.72	$ 24,772.72
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 24,772.72	$ 24,772.72

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,061 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1974	$ 35,003	1
2	TITLE WORK		1989	426	2
3	TOTALS			$ 35,429	3

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1974	1974	$ 541,766	$ 5,599	30	$	$ (5,599)	$ 541,766	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			1975	3,850		5			3,850	9
10	AIR CONDITIONING / HEATING			1974	14,470		8			14,470	10
11	MOTORS			1980	533		5			533	11
12	BIDS			1981	739	22	30	24	2	582	12
13	FURNACE			1981	678		8			678	13
14	FAN			1981	972		15			972	14
15	USED AIR CONDITIONER			1982	2,000		8			2,000	15
16	VACUUM REPAIR - PER 1982 AUDIT			1982	1,031		10			1,031	16
17	FLOORING			1983	1,229		10			1,229	17
18	WATER HEATER			1983	1,498		8			1,498	18
19	WATER HEATER			1983	1,575		8			1,575	19
20	CEILING AND DOORS			1984	2,041		15			2,041	20
21	ASPHALT			1984	13,350		15			13,350	21
22	AIR CONDITIONING			1987	1,155		8			1,155	22
23	SIDEWALKS			1987	6,700	213	20	335	122	5,528	23
24	ROOF			1988	21,783	692	20	1,089	397	16,880	24
25	LIGHT DIFFUSER			1990	1,054	33	10		(33)	1,054	25
26	FLOORING			1990	1,030	33	15	68	35	929	26
27	WATER HEATER			1992	1,450	46	15	97	51	1,211	27
28	AIR CONDITIONING			1992	1,025		10			1,025	28
29	REWIRE FIXTURES			1992	1,110	35	10		(35)	1,110	29
30	COMPRESSOR			1993	1,479	38	10	74	36	1,479	30
31	DOOR STOPS			1993	2,168	56	15	145	89	1,515	31
32	ROOF			1993	34,178	876	20	1,709	833	17,943	32
33	FIRE DOORS			1996	1,011	26	15	67	41	570	33
34	WATER HEATER			1997	3,915	100	15	261	161	1,882	34
35	AIR CONDITIONING			1997	5,982	153	10	598	445	4,186	35
36	SWAMP COOLER			1998	1,125	29	8	141	112	869	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	1998	$ 1,950	$ 50	15	$ 130	$ 80	$ 747	37
38	DOOR ENTRANCE	1999	2,672	69	15	178	109	846	38
39	SHUTTERS	1999	912	23	15	61	38	284	39
40	DOOR ENTRANCE	2000	4,507	116	15	301	185	1,251	40
41	DUCT SMOKE DETECTORS	2000	2,295	59	20	115	56	450	41
42	DOOR	2000	2,280	59	15	152	93	570	42
43	ROOFTOP AIR CONDITIONER	2001	7,619	195	10	762	567	2,159	43
44	COMBUSTION AIR DUCT	2002	710	18	15	47	29	118	44
45	SMOKE DETECTORS	2002	2,511	64	15	167	103	376	45
46	GARAGE	2002	11,636	298	15	776	478	1,681	46
47	SMOKE DETECTORS	2002	809	21	15	54	33	117	47
48	FIRE DAMPERS	2002	1,166	30	15	78	48	169	48
49	ROOFTOP AIR CONDITIONER & HEATING (2)	2002	9,766	250	8	1,221	971	1,856	49
50	GARAGE INSULATION	2003	1,652	42	15	110	68	147	50
51	ROOFTOP AIR CONDITIONER & HEATING	2003	5,300	136	8	663	527	773	51
52	PARKING LOT	2003	13,306	271	15	739	468	739	52
53	VENTILATION	2004	4,380	5	15	24	19	24	53
54	SIDEWALK & CONCRETE PAD	2003	5,900	295	20	242	(53)	242	54
55	FENCE	2004	1,453	73	8	61	(12)	61	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 751,721	$ 10,025		$ 10,489	$ 464	$ 655,521	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 176,143	$ 16,399	$ 14,854	$ (1,545)	Various	$ 98,436	71
72	Current Year Purchases	28,268	4,374	1,040	(3,334)	Various	1,040	72
73	Fully Depreciated Assets	129,062					129,062	73
74	Assets No Longer in Service	(77,603)					(77,603)	74
75	TOTALS	$ 255,870	$ 20,773	$ 15,894	$ (4,879)		$ 150,935	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,043,020	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 30,798	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 26,383	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,415)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 806,456	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: JACKSONVILLE CONVALESCENT CENTER LAND TRUST

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1974	88	8/1/74	$ 132,000			3
4	Additions							4
5								5
6								6
7	TOTAL		88		$ 132,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 7/1/03
Ending 6/30/04

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	6/30/05	$ 132,000
13.	6/30/06	$ 132,000
14.	6/30/07	$ 132,000

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ Description: INCLUDED IN THE ABOVE AMOUNT
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 8	hrs	$	2,307	$ 123,785	$	2,307	$ 123,785	1
2	Licensed Speech and Language Development Therapist	39 - 8	hrs		242	17,561		242	17,561	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 8	hrs		2,403	119,101		2,403	119,101	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 8	# of prescrpts				106,000		106,000	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): PART A ANCILLARY	39 - 8					43,227		43,227	13
14	TOTAL			$	4,952	$ 260,447	$ 149,227	4,952	$ 409,674	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER **#** 0020131 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 149,550	$ 354,788	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	371,384	371,384	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	21,273	21,273	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 542,207	$ 747,445	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		35,429	13
14	Buildings, at Historical Cost		658,844	14
15	Leasehold Improvements, at Historical Cost	91,846	91,846	15
16	Equipment, at Historical Cost	239,367	331,532	16
17	Accumulated Depreciation (book methods)	(190,539)	(895,633)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 140,674	$ 222,018	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 682,881	$ 969,463	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 234,945	$ 234,945	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	82,782	82,782	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,526	18,526	31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,159	37,159	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 373,412	$ 373,412	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 373,412	$ 373,412	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 309,469	$ 596,051	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 682,881	$ 969,463	48

***(See instructions.)**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 584,810	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 584,810	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	8,240	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) J'VILLE LAND TRUST INCOME	131,001	15
16	Other (describe) LAND TRUST DIST. TO OWNERS	(128,000)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 11,241	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 596,051	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,575,681	1
2	Discounts and Allowances for all Levels	(240,493)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,335,188	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	79,907	6
7	Oxygen	17,103	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 97,010	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,765	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,337	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,102	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	685	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 685	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING $1740 ADMIT FEE $300 W/A $208	2,248	28
28a	JURY DUTY $9 BAD DEBT RECOVERY $2571	2,580	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,828	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,441,813	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	516,599	31
32	Health Care	1,873,528	32
33	General Administration	809,189	33
	B. Capital Expense		
34	Ownership	185,945	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	48,312	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,433,573	40
41	**Income before Income Taxes (line 30 minus line 40)****	8,240	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 8,240	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,016	2,176	$ 45,847	$ 21.07	1
2	Assistant Director of Nursing	1,115	1,172	23,049	19.67	2
3	Registered Nurses	4,244	4,365	94,218	21.58	3
4	Licensed Practical Nurses	23,496	24,322	411,134	16.90	4
5	Nurse Aides & Orderlies	58,857	60,494	586,601	9.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,188	6,488	77,896	12.01	8
9	Activity Director	1,835	1,900	18,317	9.64	9
10	Activity Assistants	4,946	5,104	30,300	5.94	10
11	Social Service Workers	1,861	2,134	18,138	8.50	11
12	Dietician					12
13	Food Service Supervisor	2,245	2,383	29,029	12.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,793	10,003	71,526	7.15	15
16	Dishwashers					16
17	Maintenance Workers	3,986	4,101	36,154	8.82	17
18	Housekeepers	5,616	5,772	35,537	6.16	18
19	Laundry	3,596	3,653	20,872	5.71	19
20	Administrator	1,976	2,216	52,438	23.66	20
21	Assistant Administrator	2,000	2,080	25,623	12.32	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,422	3,675	34,362	9.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Worker	5,483	5,534	30,406	5.49	33
34	TOTAL (lines 1 - 33)	142,675	147,572	$ 1,641,447 *	$ 11.12	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	286	$ 8,814	1 - 3	35
36	Medical Director	120	12,000	9 - 3	36
37	Medical Records Consultant	16	586	10 - 3	37
38	Nurse Consultant	965	40,013	10 - 3	38
39	Pharmacist Consultant	96	1,800	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	86	5,117	12 - 3	45
46	Other(specify)				46
47	MEDICARE CONSULTANT	96	22,621	10 - 3	47
48	ADMINISTRATIVE CONSULTANT	332	10,792	17 - 3	48
49	TOTAL (lines 35 - 48)	1,997	$ 101,743		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	8	218	10 - 3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	8	$ 218		53

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LUDENE BLACK	ADMINISTRATOR	0	$ 8,475
BARBARA RANDOLPH	ADMINISTRATOR	0	43,963
DANA SEYMOUR	ASST. ADMIN.	0	25,623
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,061

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANT	$ 10,792
TOTAL (agree to Schedule V, line 17, col. 3)	$ 10,792
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
NURSING HOME MANAGERS	MANAGEMENT	$ 266,815
C S C	CORP. REPRESENTATION	298
Feldman,Wasser,Draper&Benson	LEGAL	941
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 268,054

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,351
Unemployment Compensation Insurance	34,688
FICA Taxes	122,364
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
CAFETERIA - 125 PLAN	50,859
EMPLOYEE LIFE INSURANCE	4,410
VACCINE & TESTING	1,905
CHRISTMAS PARTY	558
GIFT CERTIFICATES	1,425
EMPLOYEE APPRECIATION	182
NURSING HOME MANAGERS ALLOCATION	18,340
TOTAL (agree to Schedule V, line 22, col.8)	$ 282,082

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
VACCINE & TESTING	22	$ 1,905
CHRISTMAS PARTY	22	558
GIFT CERTIFICATES	22	1,425
EMPLOYEE APPRECIATION	22	182
TOTAL		$ 4,070

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 750
Advertising: Employee Recruitment	3,634
Health Care Worker Background Check	1,209
(Indicate # of checks performed 93)	
SEE ATTACHED SCHEDULE	4,819
J'VILLE LAND TRUST - TRUST FEES	175
NURSING HOME MANAGERS ALLOC.	44
Less: Non-allowable Dues & Fees	(470)
Less: Public Relations Expense	(3,674)
Non-allowable advertising	( )
Yellow page advertising	(540)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,947

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MISCELLANEOUS MILEAGE REIMB.	279
NURSING HOME MANAGERS ALLOC.	651
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 930

**See instructions.

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINT	7/90 - 6/91	$ 1,384	3 YRS	$	$	$	$	$	$	$	$	$
2	INTERIOR PAINT	7/92 - 6/93	1,970	3 YRS									
3	WALLPAPER & PAINT	7/93 - 6/94	6,214	3 YRS									
4	WALLPAPER & PAINT	7/94 - 6/95	3,051	3 YRS									
5	WALLPAPER & PAINT	7/96 - 6/97	4,944	3 YRS									
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 17,563		$	$	$	$	$	$	$	$	$

Facility Name & ID Number JACKSONVILLE CONVALESCENT CENTER # 0020131 Report Period Beginning: 07/01/03 Ending: 06/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **9 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **33,795** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **48,312**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **2,337**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

PAGE 3 & 4 - SCHEDULE V

LINE 27 - GENERAL ADMINISTRATION - OTHER

SALES TAX	$	5,631
BAD DEBTS		33,954
TOTAL LINE 27 - COLUMN 3	$	39,585

PAGE 3 & 4 - SCHEDULE V

DETAIL COLUMN 5 - RECLASSIFICATIONS

			LINE #
RECLASS TO:			
NURSE CONSULTANT TRAVEL:	$	3,462	10
ADMINISTRATIVE CONSULTANT TRAVEL		2,276	17
RECLASS FROM: TRAVEL	$	(5,738)	24
RECLASS FROM:			
MEDICARE SUPPLIES	$	(1,408)	10
MEDICARE X-RAYS		(3,478)	10
MEDICARE DRUGS		(102,189)	10
MEDICARE LABORATORY FEES		(8,617)	10
MEDICARE I.V. THERAPY		(3,811)	10
OXYGEN		(23,187)	10
MEDICARE OTHER ANCILLARY SERVICES		(3,209)	10
MEDICARE AMBULANCE		(3,328)	10
PHYSICAL THERAPY		(119,101)	10A
SPEECH THERAPY		(17,561)	10A
OCCUPATIONAL THERAPY	$	(123,785)	10A
RECLASS TO: ANCILLARY SERVICES		409,674	39

PAGE 9 - SCHEDULE IX - LINE 6

INTEREST PAID TO JACKSONVILLE LAND TRUST IS OFFSET ON PAGE 6
SCHEDULE VII - SECTION B - LINE 5 - RELATED ORGANIZATION TRANSACTIONS
AS PART OF JACKSONVILLE LAND TRUST INTEREST INCOME.

PAGE 13 - SCHEDULE XI - SECTION E

RECONCILIATION OF DEPRECIATION

LINE 83 - STRAIGHT LINE DEPRECIATION	$	26,383
NURSING HOME MANAGERS ALLOCATION		2,266
SCHEDULE V - LINE 30 - COLUMN 8	$	28,649

PAGE 23 - SCHEDULE XX

QUESTION #12

SALARY COSTS ARE ALLOCATED TO DEPARTMENT
WORKED BASED UPON TIME CARDS.

PAGE 19 - SCHEDULE XVII

RECONCILIATION OF INCOME	
NET INCOME - LINE 43	$ 8,240
* MANAGEMENT FEE 6/30/03	(16,824)
* MANAGEMENT FEE 6/30/04	15,807
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS	(685)
TAXABLE INCOME	$ 6,538

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR TAX PURPOSES INCLUDED HERE FOR CONSISTENCY WITH PRIOR YEAR COST REPORTS AND TO CONFORM WITH ACCRUAL ACCOUNTING METHODS.

PAGE 21 - SCHEDULE XIX - SECTION F

DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS	
PUBLIC RELATIONS	$ 3,674
CHAMBER OF COMMERCE DUES	295
FRANCHISE FEES	160
YELLOW PAGES	540
CLIA LAB FEES	150
	$ 4,819

CENTRAL OFFICE COST ALLOCATION
JACKSONVILLE
2003

	JULY 03	AUG	SEPT	OCT	NOV	DEC	JAN 04	FEB	MARCH	APRIL	MAY	JUNE	2003 TOTAL	LINE #
SALARIES-ADMIN	$3,461	$3,868	$3,820	$3,806	$3,763	$3,735	$3,632	$3,705	$3,678	$3,533	$3,422	$3,366	$43,788	17
SALARIES-CLERIC	2,524	2,588	2,556	2,546	2,517	2,499	2,513	2,563	2,545	2,445	2,367	2,329	29,991	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	
SALARIES-NURSE	631	387	382	381	376	374	643	656	651	626	606	596	6,309	10
ACCOUNTING	232	(44)	(43)	(43)	(43)	(42)	15	15	15	15	14	14	106	19
WORK COMP INS	43	4	4	4	4	4	21	22	22	21	20	20	187	22
SUPPLIES	185	90	89	89	88	87	136	138	137	132	128	126	1,425	21
TELEPHONE	185	133	131	131	129	128	139	142	141	135	131	129	1,653	21
EMPL BENEFITS	1,022	1,158	1,143	1,139	1,126	1,118	1,066	1,087	1,079	1,037	1,004	987	12,966	22
PAYROLL TAXES	562	352	348	346	342	340	493	503	499	480	465	457	5,187	22
TRAVEL	88	91	90	90	89	88	69	71	70	67	65	64	944	24
IN SERVICE	84	90	89	88	87	87	148	151	150	144	140	137	1,394	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	68	27	26	26	26	26	69	70	70	67	65	64	601	6
OWNERS COMP	222	227	225	224	221	220	215	220	218	209	203	199	2,603	17
INS-PROP,LIAB,WC	28	40	40	40	39	39	38	38	38	37	36	35	448	26
DEPRECIATION	170	200	197	197	194	193	190	194	192	185	179	176	2,266	30
RENT	468	513	506	505	499	495	473	482	479	460	445	438	5,764	34
MAINTENANCE	84	50	49	49	49	48	12	12	12	11	11	11	399	6
FEES & PUBLICAT	0	0	0	0	0	0	7	8	8	7	7	7	44	20
ADVERTISING	0	0	0	0	0	0	0	0	0	0	0	0	0	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	$10,057	$9,773	$9,652	$9,618	$9,507	$9,438	$9,879	$10,076	$10,004	$9,611	$9,306	$9,154	$116,075	
FIXED ASSETS													116,075	
EQUIP - PRIOR	11,142	11,103	10,965	10,926	10,800	10,722	16,011	16,330	16,213	15,576	15,082	14,836	13,309	
EQUIP - CURR	4,786	5,366	5,300	5,281	5,220	5,182	0	0	0	0	0	0	2,595	
EQUIP - FULLY DEP	5,143	5,124	5,061	5,043	4,985	4,949	4,982	5,081	5,045	4,847	4,693	4,616	4,964	
BLDG - PRIOR	1,812	1,805	1,783	1,776	1,756	1,743	1,755	1,790	1,777	1,707	1,653	1,626	1,749	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0	

JACKSONVILLE CONVALESCENT CENTER #0020131 07/01/03 TO 06/30/04
MONTHLY CENTRAL OFFICE
COST ALLOCATIONS

NURSING HOME MANAGERS
COST ALLOCATION
JULY 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.33%	26.94%	19.06%	13.45%	22.22%	100.00%
SALARIES-ADMIN	$0	$2,355	$3,461	$2,449	$1,728	$2,855	$12,848
SALARIES-CLERIC	0	1,717	2,524	1,786	1,260	2,082	9,370
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	429	631	447	315	521	2,343
ACCOUNTING	0	158	232	164	116	191	861
WORK COMP INS	0	29	43	30	21	35	158
SUPPLIES	0	126	185	131	92	152	686
TELEPHONE	0	126	185	131	92	152	686
EMPL BENEFITS	0	695	1,022	723	510	843	3,795
PAYROLL TAXES	0	383	562	398	281	464	2,087
TRAVEL	0	60	88	62	44	73	328
IN SERVICE	0	57	84	59	42	69	310
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	46	68	48	34	56	251
OWNERS COMP	0	151	222	157	111	183	825
INS-PROP,LIAB,WC	0	19	28	20	14	23	104
DEPRECIATION	0	116	170	120	85	140	631
RENT	0	319	468	332	234	386	1,739
MAINTENANCE	0	57	84	60	42	70	313
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,843	$10,057	$7,117	$5,021	$8,297	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	7,582	11,142	7,886	5,563	9,193	41,365
EQUIP - CURR	0	3,257	4,786	3,387	2,389	3,949	17,768
EQUIP - FULLY DEP	0	3,499	5,143	3,640	2,567	4,243	19,092
BLDG - PRIOR	0	1,233	1,812	1,282	904	1,495	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.33%	26.84%	18.24%	14.94%	21.65%	100.00%
SALARIES-ADMIN	$0	$2,641	$3,868	$2,629	$2,152	$3,120	$14,410
SALARIES-CLERIC	0	1,767	2,588	1,759	1,440	2,087	9,641
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	264	387	263	215	312	1,442
ACCOUNTING	0	(30)	(44)	(30)	(24)	(35)	(163)
WORK COMP INS	0	3	4	3	2	3	14
SUPPLIES	0	62	90	61	50	73	336
TELEPHONE	0	91	133	90	74	107	496
EMPL BENEFITS	0	790	1,158	787	644	934	4,313
PAYROLL TAXES	0	240	352	239	196	284	1,311
TRAVEL	0	62	91	62	51	74	340
IN SERVICE	0	61	90	61	50	72	334
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	18	27	18	15	21	99
OWNERS COMP	0	155	227	155	127	183	847
INS-PROP,LIAB,WC	0	28	40	27	22	33	150
DEPRECIATION	0	136	200	136	111	161	744
RENT	0	350	513	349	285	414	1,911
MAINTENANCE	0	34	50	34	28	40	186
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,673	$9,773	$6,642	$5,439	$7,884	$36,411
FIXED ASSETS							
EQUIP - PRIOR	0	7,581	11,103	7,546	6,179	8,957	41,365
EQUIP - CURR	0	3,664	5,366	3,647	2,986	4,329	19,992
EQUIP - FULLY DEP	0	3,499	5,124	3,483	2,852	4,134	19,092
BLDG - PRIOR	0	1,232	1,805	1,227	1,005	1,456	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.44%	26.51%	17.63%	15.56%	21.87%	100.00%
SALARIES-ADMIN	$0	$2,657	$3,820	$2,540	$2,242	$3,152	$14,410
SALARIES-CLERIC	0	1,778	2,556	1,699	1,500	2,109	9,641
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	266	382	254	224	315	1,442
ACCOUNTING	0	(30)	(43)	(29)	(25)	(36)	(163)
WORK COMP INS	0	3	4	3	2	3	14
SUPPLIES	0	62	89	59	52	73	336
TELEPHONE	0	91	131	87	77	108	496
EMPL BENEFITS	0	795	1,143	760	671	943	4,313
PAYROLL TAXES	0	242	348	231	204	287	1,311
TRAVEL	0	63	90	60	53	74	340
IN SERVICE	0	62	89	59	52	73	334
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	18	26	17	15	22	99
OWNERS COMP	0	156	225	149	132	185	847
INS-PROP,LIAB,WC	0	28	40	26	23	33	150
DEPRECIATION	0	137	197	131	116	163	744
RENT	0	352	506	337	297	418	1,911
MAINTENANCE	0	34	49	33	29	41	186
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,713	$9,652	$6,418	$5,664	$7,964	$36,411
FIXED ASSETS							
EQUIP - PRIOR	0	7,627	10,965	7,291	6,435	9,047	41,365
EQUIP - CURR	0	3,686	5,300	3,524	3,110	4,373	19,992
EQUIP - FULLY DEP	0	3,520	5,061	3,365	2,970	4,176	19,092
BLDG - PRIOR	0	1,240	1,783	1,185	1,046	1,471	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.76%	26.41%	17.06%	15.05%	22.72%	100.00%
SALARIES-ADMIN	$0	$2,703	$3,806	$2,459	$2,169	$3,274	$14,410
SALARIES-CLERIC	0	1,808	2,546	1,645	1,451	2,190	9,641
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	270	381	246	217	328	1,442
ACCOUNTING	0	(31)	(43)	(28)	(25)	(37)	(163)
WORK COMP INS	0	3	4	2	2	3	14
SUPPLIES	0	63	89	57	51	76	336
TELEPHONE	0	93	131	85	75	113	496
EMPL BENEFITS	0	809	1,139	736	649	980	4,313
PAYROLL TAXES	0	246	346	224	197	298	1,311
TRAVEL	0	64	90	58	51	77	340
IN SERVICE	0	63	88	57	50	76	334
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	19	26	17	15	22	99
OWNERS COMP	0	159	224	145	127	192	847
INS-PROP,LIAB,WC	0	28	40	26	23	34	150
DEPRECIATION	0	140	197	127	112	169	744
RENT	0	358	505	326	288	434	1,911
MAINTENANCE	0	35	49	32	28	42	186
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,830	$9,618	$6,212	$5,480	$8,272	$36,411
FIXED ASSETS							
EQUIP - PRIOR	0	7,759	10,926	7,057	6,226	9,397	41,365
EQUIP - CURR	0	3,750	5,281	3,411	3,009	4,542	19,992
EQUIP - FULLY DEP	0	3,581	5,043	3,257	2,873	4,337	19,092
BLDG - PRIOR	0	1,261	1,776	1,147	1,012	1,528	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.86%	26.11%	16.84%	16.01%	22.18%	100.00%
SALARIES-ADMIN	$0	$2,717	$3,763	$2,427	$2,307	$3,197	$14,410
SALARIES-CLERIC	0	1,818	2,517	1,623	1,544	2,139	9,641
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	272	376	243	231	320	1,442
ACCOUNTING	0	(31)	(43)	(27)	(26)	(36)	(163)
WORK COMP INS	0	3	4	2	2	3	14
SUPPLIES	0	63	88	57	54	74	336
TELEPHONE	0	93	129	83	79	110	496
EMPL BENEFITS	0	813	1,126	726	691	957	4,313
PAYROLL TAXES	0	247	342	221	210	291	1,311
TRAVEL	0	64	89	57	54	75	340
IN SERVICE	0	63	87	56	54	74	334
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	19	26	17	16	22	99
OWNERS COMP	0	160	221	143	136	188	847
INS-PROP,LIAB,WC	0	28	39	25	24	33	150
DEPRECIATION	0	140	194	125	119	165	744
RENT	0	360	499	322	306	424	1,911
MAINTENANCE	0	35	49	31	30	41	186
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,866	$9,507	$6,132	$5,830	$8,077	$36,411
FIXED ASSETS							
EQUIP - PRIOR	0	7,800	10,800	6,966	6,623	9,176	41,365
EQUIP - CURR	0	3,770	5,220	3,367	3,201	4,435	19,992
EQUIP - FULLY DEP	0	3,600	4,985	3,215	3,057	4,235	19,092
BLDG - PRIOR	0	1,268	1,756	1,132	1,077	1,492	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	20.59%	25.92%	16.26%	15.70%	21.52%	100.00%
SALARIES-ADMIN	$0	$2,967	$3,735	$2,344	$2,263	$3,102	$14,410
SALARIES-CLERIC	0	1,985	2,499	1,568	1,514	2,075	9,641
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	297	374	234	226	310	1,442
ACCOUNTING	0	(34)	(42)	(26)	(26)	(35)	(163)
WORK COMP INS	0	3	4	2	2	3	14
SUPPLIES	0	69	87	55	53	72	336
TELEPHONE	0	102	128	81	78	107	496
EMPL BENEFITS	0	888	1,118	702	677	928	4,313
PAYROLL TAXES	0	270	340	213	206	282	1,311
TRAVEL	0	70	88	55	53	73	340
IN SERVICE	0	69	87	54	52	72	334
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	20	26	16	16	21	99
OWNERS COMP	0	174	220	138	133	182	847
INS-PROP,LIAB,WC	0	31	39	24	24	32	150
DEPRECIATION	0	153	193	121	117	160	744
RENT	0	393	495	311	300	411	1,911
MAINTENANCE	0	38	48	30	29	40	186
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,497	$9,438	$5,922	$5,717	$7,837	$36,411
FIXED ASSETS							
EQUIP - PRIOR	0	8,517	10,722	6,727	6,495	8,903	41,365
EQUIP - CURR	0	4,116	5,182	3,251	3,139	4,303	19,992
EQUIP - FULLY DEP	0	3,931	4,949	3,105	2,998	4,109	19,092
BLDG - PRIOR	0	1,385	1,743	1,094	1,056	1,447	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	20.88%	26.10%	17.10%	14.63%	21.30%	100.00%
SALARIES-ADMIN	$0	$2,906	$3,632	$2,380	$2,036	$2,965	$13,919
SALARIES-CLERIC	0	2,011	2,513	1,646	1,409	2,051	$9,630
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	515	643	421	360	525	$2,464
ACCOUNTING	0	12	15	10	9	12	$58
WORK COMP INS	0	17	21	14	12	18	$82
SUPPLIES	0	109	136	89	76	111	$520
TELEPHONE	0	111	139	91	78	113	$532
EMPL BENEFITS	0	853	1,066	698	597	870	$4,083
PAYROLL TAXES	0	395	493	323	276	403	$1,890
TRAVEL	0	56	69	45	39	57	$266
IN SERVICE	0	119	148	97	83	121	$568
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	55	69	45	38	56	$263
OWNERS COMP	0	172	215	141	121	176	$825
INS-PROP,LIAB,WC	0	30	38	25	21	31	$145
DEPRECIATION	0	152	190	124	106	155	$728
RENT	0	378	473	310	265	386	$1,812
MAINTENANCE	0	9	12	8	7	10	$45
FEES & PUBLIC	0	6	7	5	4	6	$28
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$7,905	$9,879	$6,472	$5,537	$8,065	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	12,812	16,011	10,489	8,974	13,070	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,987	4,982	3,264	2,793	4,067	19,092
BLDG - PRIOR	0	1,404	1,755	1,150	984	1,433	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	20.75%	26.61%	17.37%	14.35%	20.92%	100.00%
SALARIES-ADMIN	$0	$2,888	$3,705	$2,418	$1,997	$2,911	$13,919
SALARIES-CLERIC	0	1,998	2,563	1,673	1,382	2,014	$9,630
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	511	656	428	354	515	$2,464
ACCOUNTING	0	12	15	10	8	12	$58
WORK COMP INS	0	17	22	14	12	17	$82
SUPPLIES	0	108	138	90	75	109	$520
TELEPHONE	0	110	142	92	76	111	$532
EMPL BENEFITS	0	847	1,087	709	586	854	$4,083
PAYROLL TAXES	0	392	503	328	271	395	$1,890
TRAVEL	0	55	71	46	38	56	$266
IN SERVICE	0	118	151	99	81	119	$568
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	55	70	46	38	55	$263
OWNERS COMP	0	171	220	143	118	173	$825
INS-PROP,LIAB,WC	0	30	38	25	21	30	$145
DEPRECIATION	0	151	194	126	104	152	$728
RENT	0	376	482	315	260	379	$1,812
MAINTENANCE	0	9	12	8	6	9	$45
FEES & PUBLIC	0	6	8	5	4	6	$28
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$7,856	$10,076	$6,577	$5,432	$7,918	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	12,732	16,330	10,659	8,803	12,833	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,962	5,081	3,317	2,739	3,993	19,092
BLDG - PRIOR	0	1,395	1,790	1,168	965	1,407	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	19.39%	26.42%	17.65%	14.65%	21.88%	100.00%
SALARIES-ADMIN	$0	$2,700	$3,678	$2,457	$2,039	$3,046	$13,919
SALARIES-CLERIC	0	1,868	2,545	1,700	1,411	2,107	$9,630
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	478	651	435	361	539	$2,464
ACCOUNTING	0	11	15	10	9	13	$58
WORK COMP INS	0	16	22	15	12	18	$82
SUPPLIES	0	101	137	92	76	114	$520
TELEPHONE	0	103	141	94	78	116	$532
EMPL BENEFITS	0	792	1,079	721	598	893	$4,083
PAYROLL TAXES	0	367	499	334	277	413	$1,890
TRAVEL	0	52	70	47	39	58	$266
IN SERVICE	0	110	150	100	83	124	$568
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	51	70	46	39	58	$263
OWNERS COMP	0	160	218	146	121	181	$825
INS-PROP,LIAB,WC	0	28	38	26	21	32	$145
DEPRECIATION	0	141	192	129	107	159	$728
RENT	0	351	479	320	265	396	$1,812
MAINTENANCE	0	9	12	8	7	10	$45
FEES & PUBLIC	0	6	8	5	4	6	$28
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$7,343	$10,004	$6,683	$5,546	$8,284	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	11,900	16,213	10,831	8,988	13,425	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,703	5,045	3,370	2,797	4,177	19,092
BLDG - PRIOR	0	1,304	1,777	1,187	985	1,471	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.90%	25.39%	17.16%	15.58%	22.98%	100.00%
SALARIES-ADMIN	$0	$2,630	$3,533	$2,388	$2,169	$3,199	$13,919
SALARIES-CLERIC	0	1,820	2,445	1,652	1,501	2,213	$9,630
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	466	626	423	384	566	$2,464
ACCOUNTING	0	11	15	10	9	13	$58
WORK COMP INS	0	16	21	14	13	19	$82
SUPPLIES	0	98	132	89	81	120	$520
TELEPHONE	0	100	135	91	83	122	$532
EMPL BENEFITS	0	772	1,037	701	636	938	$4,083
PAYROLL TAXES	0	357	480	324	294	434	$1,890
TRAVEL	0	50	67	46	41	61	$266
IN SERVICE	0	107	144	97	88	130	$568
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	50	67	45	41	60	$263
OWNERS COMP	0	156	209	142	129	190	$825
INS-PROP,LIAB,WC	0	27	37	25	23	33	$145
DEPRECIATION	0	138	185	125	113	167	$728
RENT	0	342	460	311	282	416	$1,812
MAINTENANCE	0	9	11	8	7	10	$45
FEES & PUBLIC	0	5	7	5	4	7	$28
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$7,154	$9,611	$6,495	$5,900	$8,700	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	11,594	15,576	10,527	9,561	14,099	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,608	4,847	3,275	2,975	4,387	19,092
BLDG - PRIOR	0	1,271	1,707	1,154	1,048	1,545	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	19.11%	24.58%	17.31%	16.54%	22.45%	100.00%
SALARIES-ADMIN	$0	$2,660	$3,422	$2,410	$2,303	$3,125	$13,919
SALARIES-CLERIC	0	1,841	2,367	1,667	1,593	2,162	$9,630
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	471	606	427	408	553	$2,464
ACCOUNTING	0	11	14	10	10	13	$58
WORK COMP INS	0	16	20	14	14	18	$82
SUPPLIES	0	99	128	90	86	117	$520
TELEPHONE	0	102	131	92	88	119	$532
EMPL BENEFITS	0	780	1,004	707	676	917	$4,083
PAYROLL TAXES	0	361	465	327	313	424	$1,890
TRAVEL	0	51	65	46	44	60	$266
IN SERVICE	0	108	140	98	94	127	$568
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	50	65	46	44	59	$263
OWNERS COMP	0	158	203	143	136	185	$825
INS-PROP,LIAB,WC	0	28	36	25	24	32	$145
DEPRECIATION	0	139	179	126	120	163	$728
RENT	0	346	445	314	300	407	$1,812
MAINTENANCE	0	9	11	8	7	10	$45
FEES & PUBLIC	0	5	7	5	5	6	$28
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$7,236	$9,306	$6,555	$6,263	$8,499	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	11,727	15,082	10,623	10,151	13,775	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,649	4,693	3,305	3,159	4,286	19,092
BLDG - PRIOR	0	1,285	1,653	1,164	1,113	1,510	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2004

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	19.54%	24.18%	17.81%	16.37%	22.10%	100.00%
SALARIES-ADMIN	$0	$2,720	$3,366	$2,479	$2,279	$3,075	$13,919
SALARIES-CLERIC	0	1,882	2,329	1,715	1,577	2,128	9,630
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	482	596	439	403	544	2,464
ACCOUNTING	0	11	14	10	10	13	58
WORK COMP INS	0	16	20	15	13	18	82
SUPPLIES	0	102	126	93	85	115	520
TELEPHONE	0	104	129	95	87	118	532
EMPL BENEFITS	0	798	987	727	668	902	4,083
PAYROLL TAXES	0	369	457	337	309	418	1,890
TRAVEL	0	52	64	47	44	59	266
IN SERVICE	0	111	137	101	93	125	568
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	51	64	47	43	58	263
OWNERS COMP	0	161	199	147	135	182	825
INS-PROP,LIAB,WC	0	28	35	26	24	32	145
DEPRECIATION	0	142	176	130	119	161	728
RENT	0	354	438	323	297	400	1,812
MAINTENANCE	0	9	11	8	7	10	45
FEES & PUBLIC	0	6	7	5	5	6	28
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$7,400	$9,154	$6,743	$6,198	$8,365	$37,859
FIXED ASSETS							
EQUIP - PRIOR	0	11,992	14,836	10,927	10,044	13,557	61,357
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,732	4,616	3,400	3,125	4,218	19,092
BLDG - PRIOR	0	1,314	1,626	1,198	1,101	1,486	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

ALLOCATION PERCENTAGES USED ON
MONTHLY ALLOCATIONS - PAGE 28

OCCUPIED DAYS 2003	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY		1,766	2,534	1,785		1,407	2,244	9,736
FEBRUARY		1,613	2,267	1,630		1,165	2,000	8,675
MARCH		1,782	2,563	1,878		1,263	2,188	9,674
APRIL		1,745	2,414	1,858		1,261	2,113	9,391
MAY		1,733	2,544	1,839		1,305	2,248	9,669
JUNE		1,667	2,359	1,734		1,266	2,110	9,136
JULY		1,746	2,566	1,816		1,281	2,117	9,526
AUGUST		1,752	2,566	1,744		1,428	2,070	9,560
SEPTEM		1,702	2,447	1,627		1,436	2,019	9,231
OCTOBER		1,847	2,601	1,680		1,482	2,237	9,847
NOVEMBER		1,796	2,487	1,604		1,525	2,113	9,525
DECEMBER		2,051	2,582	1,620		1,564	2,144	9,961
TOTAL	0	21,200	29,930	20,815	0	16,383	25,603	113,931
								113,931

OCCUPIED DAYS 2004	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY		2,030	2,537	1,662		1,422	2,071	9,722
FEBRUARY		1,886	2,419	1,579		1,304	1,901	9,089
MARCH		1,904	2,594	1,733		1,438	2,148	9,817
APRIL		1,814	2,437	1,647		1,496	2,206	9,600
MAY		1,838	2,364	1,665		1,591	2,159	9,617
JUNE		1,847	2,285	1,683		1,547	2,088	9,450
JULY		1,881	2,437	1,679		1,617	2,176	9,790
AUGUST								0
SEPTEM								0
OCTOBER								0
NOVEMBER								0
DECEMBER								0
TOTAL	0	13,200	17,073	11,648	0	10,415	14,749	67,085
								67,085

ALLOCATION PERCENTAGE 2003	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.00%	18.14%	26.03%	18.33%	14.45%	23.05%	100.00%
FEBRUARY	0.00%	18.59%	26.13%	18.79%	13.43%	23.05%	100.00%
MARCH	0.00%	18.42%	26.49%	19.41%	13.06%	22.62%	100.00%
APRIL	0.00%	18.58%	25.71%	19.78%	13.43%	22.50%	100.00%
MAY	0.00%	17.92%	26.31%	19.02%	13.50%	23.25%	100.00%
JUNE	0.00%	18.25%	25.82%	18.98%	13.86%	23.10%	100.00%
JULY	0.00%	18.33%	26.94%	19.06%	13.45%	22.22%	100.00%
AUGUST	0.00%	18.33%	26.84%	18.24%	14.94%	21.65%	100.00%
SEPTEMBER	0.00%	18.44%	26.51%	17.63%	15.56%	21.87%	100.00%
OCTOBER	0.00%	18.76%	26.41%	17.06%	15.05%	22.72%	100.00%
NOVEMBER	0.00%	18.86%	26.11%	16.84%	16.01%	22.18%	100.00%
DECEMBER	0.00%	20.59%	25.92%	16.26%	15.70%	21.52%	100.00%

ALLOCATION PERCENTAGE 2004	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.00%	20.88%	26.10%	17.10%	14.63%	21.30%	100.00%
FEBRUARY	0.00%	20.75%	26.61%	17.37%	14.35%	20.92%	100.00%
MARCH	0.00%	19.39%	26.42%	17.65%	14.65%	21.88%	100.00%
APRIL	0.00%	18.90%	25.39%	17.16%	15.58%	22.98%	100.00%
MAY	0.00%	19.11%	24.58%	17.31%	16.54%	22.45%	100.00%
JUNE	0.00%	19.54%	24.18%	17.81%	16.37%	22.10%	100.00%
JULY	0.00%	19.21%	24.89%	17.15%	16.52%	22.23%	100.00%